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**Interventions**

Articles testing the applied science and implementation of mindfulness-based interventions


Panahi, F., Faramarzi, M. (2017). The effects of mindfulness-based cognitive therapy on
depression and anxiety in women with premenstrual syndrome. *Depression Research and Treatment.* [link]


**ASSOCIATIONS**

*Articles examining the correlates and mechanisms of mindfulness*


**METHODS**

Articles developing empirical procedures to advance the measurement and methodology of mindfulness


intervention for people with Parkinson’s disease: The study protocol of a randomised pilot trial. *Pilot and Feasibility Studies.* [link]


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**REVIEWS**

*Articles reviewing content areas of mindfulness or conducting meta-analyses of published research*


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**TRIALS**

*Research studies newly funded by the National Institutes of Health (JAN 2017)*

None reported.
Highlights

A summary of select studies from the issue, providing a snapshot of some of the latest research

Social Anxiety Disorder (SAD) is a psychiatric condition affecting approximately 7% of Americans. Symptoms include fear, embarrassment, and humiliation in social situations, along with avoidance of social interactions. People with SAD have negative beliefs about their social acceptability and self-worth, creating fear that others will discover their self-perceived negative qualities. Altering these negative self-beliefs may be an effective way to reduce the severity of SAD symptoms. Thurston et al. [Journal of Anxiety Disorders] conducted a randomized, controlled study to test the effects of Mindfulness-Based Stress Reduction (MBSR) and Cognitive Behavioral Group Therapy (CBGT) on positive and negative self-evaluations and their relationship to social anxiety symptoms in patients with SAD.

The researchers randomly assigned 108 volunteers (56% female; mean age = 33 years; 43.5% Caucasian, 39% Asian, 9.3% Hispanic, 8.3% other) with SAD to a 12-week MBSR program, CBGT program, or wait-list control. The volunteers completed a Self-Referential Encoding Task (SRET) and a self-report scale of social anxiety at baseline and after the assigned intervention. The SRET was also completed by a separate group of 40 healthy controls that served as a baseline comparison group. The SRET measures participants’ positive and negative self-views by having them select the words that best describe themselves from pairs of computer-presented negative and positive adjectives.

The standard curriculum-based MBSR intervention omitted the usual “retreat day” in the sixth week of the program, but extended the program by adding four additional weekly group sessions so that it better matched the 12-week CBGT program. The CBGT program taught cognitive restructuring and relapse prevention and offered graded exposure to feared social situations, both in-program and the “real world.” Wait-listed controls did not participate in any intervention during the 12 weeks between baseline and post-intervention assessments.

At baseline, participants with SAD had significantly higher negative self-views (Cohen’s $d=2.9$) and lower positive self-views ($d=2.4$) than the healthy control comparison group. There was a significant negative association ($r=-.26$) between positive self-views and social anxiety symptoms. After intervention, MBSR participants showed significant increases in positive self-views ($d=0.09$) and decreases in negative self-views ($d=1.1$). CBGT participants showed increases in positive self-views ($d=0.7$) and decreases in negative self-views ($d=0.8$) of similar magnitude. Wait-listed controls showed smaller magnitude increases in positive self-views ($d=0.03$) and decreases in negative self-views ($d=0.04$).

The MBSR and CBGT groups increased positive self-views by 19 and 17 points respectively, while the wait-listed controls increased their positive self-views by only 7 points. MBSR participants had significantly larger improvements than wait-listed controls yet their improvements were not significantly different from those of CBGT participants. For both MBSR ($R^2=0.23$) and CBGT ($R^2=0.27$), improvements in positive self-views were associated with improvements in social anxiety symptoms. Decreases in negative self-views, however, had no effect on social anxiety symptoms.

The results show that MBSR and CBGT are equally effective in increasing positive self-views and decreasing social anxiety in people diagnosed with SAD. They may each achieve the same result, however, through different mechanisms. For example, CBGT may increase positive self-views through cognitive restructuring, and MBSR through enhanced cognitive flexibility and decreased
attachment to prior notions of the self. The possible differences in mechanisms were not explicitly tested in this study, however. The finding that increased positive self-views are associated with symptom improvement while decreased negative self-views are not suggests that an increased focus on cultivating positive self-views may be more effective than disputing negative ones among people with SAD.

What percentage of Americans practice mindfulness meditation, and how do they differ from those who do not? Every year the Centers for Disease Control and Prevention's National Center for Statistics (NCS) conducts an annual National Health Interview Survey using U.S. Census Bureau-trained interviewers. They visit some 35,000-40,000 households, obtaining self-report health data from a representative sample of 75,000-100,000 Americans, which provides the most complete snapshot of the nation's health in any given year. Additionally, every five years, the NCS and the National Center for Complementary and Integrative Health conjointly collect supplementary data on the use of alternative and complementary medicine. Morone et al. [Journal of Alternative and Complementary Medicine] analyzed data from the 2012 surveys to assess the prevalence of mindfulness meditation practice, who uses it, and why.

The 2012 NHIS survey collected information from 108,131 adults. The researchers examined the data from respondents who reported using "mindfulness meditation including Vipassana, Zen Buddhist meditation, Mindfulness-based Stress Reduction and Mindfulness-based Cognitive Therapy" during the previous 12 months. It also compared them to respondents who reported they did not practice mindfulness meditation on various demographic variables, health behaviors, acute and chronic illnesses, and physical and mental health issues.

On the basis of this data, the researchers estimated that well over two million American adults engaged in mindfulness meditation in 2012. Women made up 61% of the mindfulness meditators. As a group, mindfulness meditators were an average of seven years older than non-meditators, and while more likely to be white and college educated, did not differ in terms of socio-economic status. Mindfulness meditation practice was more prevalent in Western states, and less prevalent in the South.

Mindfulness meditators were more likely to smoke, but also more likely to engage in regular moderate exercise. Mindfulness meditators (mean BMI = 27.3 kg/m²) were less likely to be obese than non-meditators (mean BMI = 30.6 kg/m²). While mindfulness meditators were 12-15% more likely to report aches and pains and 19% more likely to report acute head and chest colds, they were 3-11% less likely to report chronic diseases such as hypertension, heart disease, and COPD. On the other hand, mindfulness meditators were 10% more likely to report mental disorders, 26% more likely to report having been nervous, 11% more likely to report having been sad, 16% more likely to report feeling stressed, and 27% more likely to report having had insomnia. All of these differences were statistically significant.

The observed higher levels of pain and negative emotions in mindfulness meditators is probably due to the fact that these are the symptoms that often motivate people to start meditating, rather than being the result of meditation. The results suggest that with the notable exception of smoking, meditators are generally more likely to engage in healthy behaviors and, despite their older age, be less likely to be obese or report a variety of chronic illnesses. Their increased likelihood of smoking may reflect their greater levels of anxiety, sadness, mental illness, and stress, which may also account for their increased frequency of acute colds. This study broadens our understanding of who currently engages in mindfulness meditation in the U.S. and why. The study is limited by the lack of information on practitioners' duration, frequency, and consistency of mindfulness practice.
This two-day meeting will highlight the latest research findings and their applications by researchers and practitioners whose work promotes the well-being of children and families.

**Keynote addresses by Richie Davidson and Mark Greenberg**

**Opening addresses by Angela Rose Black and India Ornelas on mindfulness in diverse communities**

**Symposia include:**

- Mindful parenting and child well-being
- Sharing mindfulness in pre- and peri-natal contexts
- Cultivating mindfulness in youth to enhance self-regulation
- Compassion and self-compassion based interventions
- Promoting trauma-informed mindfulness practices

**Friday & Saturday, April 28 & 29, 2017  UW Center for Urban Horticulture** Seattle, WA

For details visit the conference website: [depts.washington.edu/ccfwb/2017conference](http://depts.washington.edu/ccfwb/2017conference)